KANSAS STATE BOARD OF PHARMACY

Application to Provide Hospital Electronic Supervision Services

(If applying for more than one remote pharmacy location, a separate application must accompany each request.)

1 PROVIDER PHARMACY INFORMATION

Name of the Pharmacy that will be PROVIDING the electronic supervision — KS Registration Number

Address — Telephone Number

Name of Pharmacist-In-Charge — KS License Number

2 HOSPITAL REQUESTING REMOTE SERVICE INFORMATION

Name of the Hospital Pharmacy RECEIVING remote electronic supervision services — License Number

Address

Name of Pharmacist-In-Charge — Hours of Operation:

Telepharmacy System (Attach copies of the following.)

(1) Documentation that the hospital / medical care facility in which the automated pharmacy system will be located is either:
   (a) critical access hospital pursuant to K.S.A. 65-468; or
   (b) a medical care facility defined in K.S.A. 65-425 (a) general hospital.
   (Attach a copy of the KDHE hospital registration).

(2) Documentation that the electronic supervision oversight is located in a medical care facility:
   (a) a medical care facility defined in K.S.A. 650425 (a) general hospital.

(3) Copy of the training manual related to electronic supervision of a pharmacy technician.

(4) Attach specifications of the system applications used to provide the services

(5) Attach a list of pharmacy technicians that will work under electronic supervision.

4 ATTEST STATEMENTS

Regarding Written Contract or Agreement – Attach agreement

I hereby attest that the provider pharmacy and the remote facility have a written contract or agreement which outlines the services to be provided and the responsibilities and accountabilities of each party in fulfilling the terms of the contract or agreement in compliance with federal and state laws and regulations. The financial aspects of the contract can be redacted.

Regarding Application

I hereby attest that the foregoing statements, as well as those on the reverse side of this form or those on any attachment(s) to this form, are to the best of my knowledge true and correct and that they are all given of my free will. I agree that any misstatements(s) or omission(s) as to material facts will constitute violation of and subject me to the penalties set forth in the Kansas Pharmacy Act. I agree to comply with the Kansas Pharmacy Act and Rules.

SIGNATURES MUST BE NOTARIZED!

Signature - Pharmacist-in-Charge of Hospital requesting electronic supervision services. Date

Type or Print Name

Before me, a Notary Public, on this day personally appeared _____ known to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that they executed the same for the purpose and consideration therein expressed. Given under my hand and seal of office this _____ day of _____ 20 _____

Notary Public, State of _____